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THESIS

MENTAL HEALTH SERVICES IN THE MARINE CORPS: AN EXPLORATORY STUDY OF STIGMA AND POTENTIAL BENEFITS OF DESTIGMATIZATION TRAINING WITHIN THE OPERATIONAL STRESS CONTROL AND READINESS (OSCAR) PROGRAM

by

Susanna R. Cooper

December 2004

Thesis Co-Advisors: Gail Thomas
Roderick Bacho

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This study examines stigma associated with mental health services counseling in the Marine Corps for the purpose of assessing areas of concern where lack of awareness or stigma exists. Marines with longstanding unresolved personal problems or more immediate emotional distress may be less effective, they may also not know where to go for help. Secondly, stigma may be associated with the fear of negative performance evaluations and decreased future promotions, which may reflect an underutilization of the available mental health services. Results of this study reflect: 1)that stigma does exist; 2)that Marines have a poor knowledge of the availability and variety of mental health services; 3)that there is little in the way of destigmatization training within the Marine Corps. By studying civilian models which may have a destigmatization component, this study presents possible methods for incorporating destigmatization training into the OSCAR program. Theoretically, the results of this study, garnered through interviews with practitioners, literature, and an OSCAR program review, can be used to further the efficacy of Marine Corps mental health services by way of education and destigmatization training.

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MENTAL HEALTH SERVICES IN THE MARINE CORPS: A QUALITATIVE STUDY OF STIGMA AND POTENTIAL BENEFITS OF DESTIGMATIZATION TRAINING WITHIN THE OSCAR (OPERATIONAL STRESS CONTROL AND READINESS) PROGRAM

Susanna R. Cooper
Captain, United States Marine Corps
B.A., East Carolina University, 1995
M.A., Norfolk State University, 2001

Submitted in partial fulfillment of the
requirements for the degree of

MASTER OF SCIENCE IN LEADERSHIP AND HUMAN RESOURCE DEVELOPMENT

from the

NAVAL POSTGRADUATE SCHOOL
December 2004

Author: Susanna R. Cooper

Approved by: Gail Fann Thomas, Ed.D.
Thesis Co-Advisor

LCDR Roderick Bacho, Ph.D.
Thesis Co-Advisor

Douglas A. Brook, PhD
Dean, Graduate School of Business and Public Policy

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ABSTRACT

This study examines stigma associated with mental health services counseling in the Marine Corps for the purpose of assessing areas of concern where lack of awareness or stigma exists. Marines with longstanding unresolved personal problems or more immediate emotional distress may be less effective, they may also not know where to go for help. Secondly, stigma may be associated with the fear of negative performance evaluations and decreased future promotions, which may reflect an underutilization of the available mental health services. Results of this study reflect: 1)that stigma does exist; 2)that Marines have a poor knowledge of the availability and variety of mental health services available; 3)that there is little in the way of destigmatization training within the Marine Corps. By studying civilian models for destigmatization training, this study presents possible methods for incorporating destigmatization training into the OSCAR program. Theoretically, the results of this study, garnered through interviews with practitioners, literature, and OSCAR program policy makers can be used to further the efficacy of Marine Corps mental health services by way of education and destigmatization training.

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My interest in the human condition is what led to my studies in psychology. And it is in recognition to the Marine Corps that my interest has remained so active and that I give thanks. The Marine Corps provided a dynamic and challenging environment where I was able to fulfill my obligations as a Combat Service Support Officer. Likewise, that very same environment provided me with a host of experiences that resonated with themes of diversity, compassion, concern, care (troop welfare), leadership, motivation, and a host of other essentials that are elements of the human condition. Also, I feel gratitude to the Naval Postgraduate School (for the curriculum that made this thesis possible) and the U.S. Naval Academy (for the LEAD program that made this thesis possible, as well as the awesome opportunity to be a Company Officer at such a fine institution). Specifically, I acknowledge the advice, help, and assistance of my advisors, Roderick Bacho and Gail Fann Thomas. And lastly, I acknowledge my two sons, Devon and Brett, who have magnified my interest in the human condition immeasurably. It is for your future freedoms that I continue to serve and for your mental health that I keep questioning.

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I. INTRODUCTION

A. BACKGROUND

A March 2004 article in the Army Times (Maze) reported that “a briefing on the results of a mental health survey of troops in Iraq was abruptly canceled . . . because military officials said they did not want bad news to come out on the eve of the anniversary of Operation Iraq Freedom.” The congressional sources in this statement indicate that the mental health of the soldiers was a concern.

Reviewing a brief history of mental health in early wars clearly reflect the advancements in recognizing psychological problems as serious but not necessarily debilitating. Dr. John Neill (1993) studied the differences, in terms of psychiatric symptoms, in the two World Wars. He found that World War I practitioners recognized combat psychiatric casualties as men with hysteria and root causes of a genetic nature were investigated. World War II practitioners saw an increased incidence of psychosomatic illness. The illnesses were complex, subtle, and led the way to the naming of combat fatigue, which is now better known as Post Traumatic Stress Disorder (PTSD).

Additionally, in World War II, psychiatrists moved away from stigmatizing combat psychiatric casualties as those with a genetic weakness towards hysteria like in World War I. They consequently saw combat as being a stressor that could lead mentally healthy individuals to experience nervous breakdowns, “without invoking the notion of major mental illness or insanity.” (pg 151)

Later studies (Neil, 1993), specifically those researching aspects of the Vietnam War, were concerned about the long-term effects of the above mentioned nervous breakdowns or Post Traumatic Stress Disorder (PTSD) on service members. One study by Koenen and Stellman (1998) assessed Vietnam Vets 35 years after combat against a control group of non-Vietnam veterans. They found that incomes were lower for those veterans who experienced a high incidence of combat. This same group had a decrease in marital happiness, life happiness, and general life satisfaction. They also smoked more. Even veterans who had a low incidence of combat time showed a significantly higher "anger/irritation" score than non-veterans (pg 449).

A retired veteran's center counselor and disabled Vietnam Veteran, Steve Tice, refers to those Veterans who live alone with tormenting memories as the "invisible wounded" (Corbett, 2004). Corbett's article, in addressing the possible aftermath of the IRAQ war on veterans' mental health, also discusses the past:

> Even as the military works to provide mental-health care, history shows that the vast majority of soldiers returning from war will never seek help. Or they will do it years later, when the psychological after-burn has wreaked havoc on their lives.

Tice (Corbett, 2004) indicates that soldiers do not say "I'm hurt," because there is a stigma associated with it.

The long-term effects on veterans and our society are without a doubt one of the reasons continued improvements in counseling services are so critical. The price that

veterans, their families, and ultimately taxpayer dollars, pay will only increase over time if psychological illnesses are left untreated.

Recent news stories discuss what may be a growing trend in conflict and war, what many call the hidden casualties of war. The hidden casualties refer to suicide rates and the emotional and mental well-being of U.S. military service members Beaumont, 2004).

A service member's readiness for combat is degraded when stress is internalized to the point that normal functioning is impaired. Stress, when not dealt with properly can lead to more than reduced combat readiness, and in extreme cases may cause service members to take their lives in an attempt to reduce the pain and frustration of reduced mental health.

B. PURPOSE

The purpose of this research was to ascertain if stigma exists and to study the negative impact of stigma on utilization of mental health services by Marines. Also, the study looked at the implications of implementing a destigmatization program that can be incorporated into the United States Marine Corps' (USMC) Operational Stress Control and Readiness (OSCAR) program ("Division Order," 2001).

C. RESEARCH QUESTIONS

Specific research questions follow:

Primary Questions:

1) Do mental health practitioners perceive a stigma associated with the use of mental health services in the Marine Corps?

2) Should destigmatization practices be implemented into the OSCAR program?

Secondary Questions:

1) What mental health problems are associated with military personnel in general, and with U.S. Marines, in particular?

2) What mental health services are available to U.S. Marines?

3) What is known about stigma as it relates to military health services?

4) What are the history and goals of the U.S. Marine Corps' Operational Stress Control and Readiness Program?

5) How is destigmatization training conducted in civilian mental health programs?

D. RESEARCH METHODS

The methods used in this study consisted of the following steps:

1) A literature search of books, journal articles, CD-ROM systems, and other library information resources regarding stigma of mental health services (in the military and civilian sectors).

2) A review of the current OSCAR program and other available mental health services resources. This was accomplished through obtaining the Standard Operating Procedures (SOP) from the Division that first implemented the pilot study, 2nd Marine Division at Camp Lejeune, NC. Additional materials viewed included information from Headquarters Marine Corps Health Services, a Marine

Requirements Oversight Council (MROC) Executive Study, and a MROC Decision Memorandum.

3) Interviews with three practitioners who work in military mental health services for the Marine Corps; specifically, practitioners from the Fleet & Family Services Center, from outpatient Psychology, and a Navy Chaplain. The practitioners provided their views on the existence of stigma and the impact of stigma on the utilization of services (see Appendix for interview protocol). A primary purpose of the practitioner interviews was to assess perceived stigma for illustrative purposes. The interviews were also designed to obtain Marine Corps specific information since the literature regarding stigma is derived mainly from the civilian sector or as it related, primarily to the other three branches of the military service. It is also important to note that the interviews did not seek to confirm or deny conclusively that stigma exists, but presents the *perceptions* regarding stigma by the practitioners.

4) Identification of possible methods of incorporating destigmatization training into the OSCAR program was conducted by reviewing example civilian destigmatization programs. Specific organizations that were contacted by email, phone conversation, or by mail follow:

- National Stigma Clearinghouse
- National Mental Health Association (NMHA)
- National Alliance for the Mentally Ill (NAMI)
- National Institute of Mental Health
- The Center for Mental Health Services

- The Carter Center Mental Health Program
- Stigmabusters

Additionally, the American Counseling Association (ACA), the American Psychiatric Association, and the American Psychological Association were utilized in the search for information on the topic of stigma.

E. PERSONAL EXPERIENCE

As a Marine of sixteen years I have been touched by those who were not mentally healthy. As a Lance Corporal, I experienced the suicide of a Staff Sergeant living two doors down from me in the Barracks. He hung himself with his web belt. As a Legal Clerk in the same squadron that he belonged to, I also worked on the Judge Advocate General (JAG) investigation that was required.

Years later, I helped with a JAG investigation that involved a Marine Captain, an aviator, who committed suicide in his garage. As a Legal Chief, and later as a Legal Officer, I assisted in processing myriad administrative discharge packages on Marines with, among other things, conduct problems, adjustment disorders, and personality disorders. While completing an Internship for a graduate degree in Counseling, I manned a Crisis Line, Mental Health/Substance Abuse Hospital after-hours service, and the Richmond area National Suicide Hotline. I was greatly surprised by the number of military service members and respective family members that called. After all, we have complete medical services available to us in the Marine Corps. But, so many seek help outside of the military. This concerns me and provided the motivation for this thesis.

F. SCOPE, LIMITATIONS, AND ASSUMPTIONS

The scope of this study broadly looks at general military stigma associated with utilizing mental health services. Additionally, it looks at the usefulness of destigmatization programs for combating Marines' reticence to seek available services.

This study was limited by a lack of specific Marine Corps quantitative data. Additionally, a study that researches the enlisted population at large would also be beneficial in confirming practitioner and literature viewpoints.

As indicated, without the use of an enlisted-wide study, the thesis assumes that the stigma mentioned in the literature, as well as the practitioner interviews, are sufficient in establishing the need for a destigmatization program. An additional assumption is the relatedness of the assessed stigma from the civilian sector and the other military services, as there is little Marine Corps specific research.

G. BENEFITS OF THE STUDY

The results of this study may lead to a greater awareness concerning the reasons why mental health-care services may be underutilized. Ultimately, the significance and benefit of studying stigma and ways to address it relates to ensuring operational readiness of Marines who are mentally healthy.

H. ORGANIZATION OF STUDY

The following chapters address stigma, the OSCAR program, and destigmatization training. Chapters II and III presents an overview of current available mental health

services and a literature review of stigma in the civilian and military sectors. Chapter IV presents the results of the practitioner interviews, the results from the OSCAR program review, and results from the civilian destigmatization programs that were reviewed. Chapter V presents conclusions as well as recommendations for further research.

II. MENTAL HEALTH IN THE U.S. MILITARY

A. INTRODUCTION

Despite the existence of various mental health programs and initiatives, Marines may still underutilize these services due to a lack of awareness or limited access. McCarroll's (1993) Army study showed that even more senior service members, when dealing with a problem, state that the reason for not obtaining help earlier is because they "didn't know where to go for help" (p.707). Based on this lack of knowledge it would seem plausible that more junior Marines with less experience in life and in the Marine Corps would be that much more vulnerable to troubles that they are experiencing and finding ways of obtaining help.

Where help is known, it may logistically be difficult to travel to the services. For instance, inaccessibility may be considered an issue by some at Camp Hansen in Okinawa where services are 20 miles away. Transportation is oftentimes a problem area for young Marines who do not possess privately owned vehicles. Transportation can also become a burden to the unit, especially during the busiest of times such as exercises or work-ups. Although most units have a duty driver for reasons such as these the affected Marines can be sensitive to the burden that they feel is imposed on the unit. As well, they may feel that their privacy is compromised by a potentially unknown duty driver delivering them to a counseling appt, etc. Privacy and confidentiality will be discussed further in subsequent sections.

Another potential problem influencing the possible underutilization of Mental Health Services is the stigma associated with it. The stigmas may include the feeling that seeking help is a sign of weakness or a form of malingering to evade service. Such stigmas may prevent a Marine, who is indeed aware of the services, from seeking help (Hoge et al., 2002; Johnson, 1995; Malone, 2002; Johnson & Porter, 1994). The degree, if any, that stigma exists and whether or not it is something that the Marine Corps should be concerned about will be discussed in further depth in Chapter III.

Prior to a discussion of stigma, however, it is important to understand some of the concerns that are related to Mental Health Services in the Marine Corps. This chapter will address many of those concerns, such as stress, attrition, and suicide. It will also examine the relationship between psychotherapy and medical utilization, as well as present current counseling services available and two of the most recent initiatives which augment the specialized service areas.

B. MENTAL HEALTH PROBLEMS IN THE U.S. MILITARY

Military service can result in psychological and social problems that adversely affect performance. In fact, one study suggested that the military setting might be an increased causal factor in contributing to mental illness (Malone, 2002). The recent attention that stress has garnered and the changing combat environments that Marines face pose additional complex problems that affect the Marine psyche and are worthy of discussion. Problems such as attrition and suicide will always plague the

military as it does in the civilian sector, however continued efforts at decreasing the numbers is still a worthwhile goal.

1. Stress

We continue to lament wasted training dollars spent on Sailors and Marines who never complete their initial contracts. We read stories about soldiers at Fort Bragg who killed their spouses. And we slowly learn that physical ailments which detract from mission accomplishment and wasted man-hours on the job are many times a physical symptom of a psychiatric problem, what psychologists call psychosomatic. In many of these cases, stress was found to have been very high.

The full extent of the ill physical and psychological effects of stress is a somewhat new phenomenon. To understand how it became part of the military lexicon, it may be worthwhile to present a brief picture as to how Military Psychology began deeming stress as important enough to study and concentrate on, as it is being studied in the civilian sector.

In the beginning, Military Psychology began with the then President of the American Psychological Association (APA) promoting a call to arms during World War I. This call produced twelve APA committees that assisted with the war effort in numerous ways from examination and identification of recruits to education of hospital staff. Currently, DOD is considered the largest employer of Psychologists in the nation (Cronin, 1998). As the times have changed, so have the emphasis on what military psychology considers important to concentrate on. Stress

is one of those many new concepts that have grabbed the attention of leaders and psychologists alike.

Stress, which used to be thought of as anxiety in days of old, was coined by Hans Selye in 1956 with his book, The Stress of Life (1978). He began what is now an extensive body of knowledge surrounding the short-term and long-term effects of stress on an individual. As with testing that began with military recruits and which has now joined the civilian sector, Post Traumatic Stress Disorder (PTSD), a particular form of stress, was observed and studied in the major world wars and is now listed in the DSM IV as a disorder affecting civilians and soldiers alike.

The findings that were the outcome of past PTSD studies were quite interesting and negated a strictly neuro-physiological argument for those who succumbed to the ravages of war. The previous belief, by primarily psychiatrists, that combat stress casualties were the result of "pre-existing neuroses or psychopathology changed to a recognition of situational factors, duration, unit cohesion and personality traits as factors in developing PTSD" (Cronin, 1998).

More recently, neuro-science has made great strides in linking stress to heart disease and length of life. In fact, Sapolsky, in his book Why Zebras Don't Get Ulcers provides evidence that stress can affect such areas as lowered immunity, flatulence, analgesia, memory, metabolism, colitis, glands and much more (1994).

And now the military is paying great attention to the topic of stress. Pflanz (2002) noted that past research has indeed linked stress to military members in combat and

even in humanitarian roles and disaster relief missions. However, he also noted research that reflects military members as a whole, regardless of contact with actual combat, experience higher than normal stress as compared to the civilian population. A few interesting findings from Planz' study of Air Force Personnel are presented here.

- The military personnel studied were significantly more likely to report suffering from job stress than civilian workers.
- One-quarter, (26%) reported suffering from significant work stress.
- 15 percent reported that work stress was causing them significant emotional stress.
- 8 percent reported experiencing work stress that was severe enough to be damaging their emotional health.

The above results support the notion that stress may be an occupational health hazard for military personnel (Pflanz, 2002).

Pflanz lists several non-combat related military events, such as overseas deployments, lack of control over duty assignments, and permanent change of station orders as suggested stressors. But, because 9% or less of the studied personnel listed these military specific stressors as causation factors individual to them, he suggested that "job stress in the military may have little to do with the fact that military personnel deal with the difficult business of war and may stem from more subtle aspects of military culture . . . " (pg. 878). He and others such as

Mazokopakis (2002) suggest aspects of lack of autonomy, the military hierarchical structure, and a dissonance in personal ideology that is not always compatible with the military ethos as possible stressors that are yet unaccounted for consciously by individuals or listed in the literature. Table 1 lists some of the stated reasons for stress from Planz's study.

Table 1. Frequency of Military and Occupational Stressors in the U.S. Air Force

Stressor	**Percentage of Participants Experiencing the Stressor**
Change in responsibilities at work	46
Change in work hours or conditions	34
Change to a different line of work	17
Permanent change of station	15
Trouble with supervisors	11
Bypassed for promotion	10
Minor military disciplinary action	8
Business readjustment	8
Frequent temporary duty away from home	7
Involuntary assignment	6
Marital separation due to orders	5
Deployment in a war zone	3
Extended temporary duty away from home	2
Overseas tour	2
Major military disciplinary action	1
Fired at work	1
Remote tour	1
Reduction in rank	1
Retirement	1
Voluntary separation from military	<1

Note. From “Work Stress in the Military: Prevalence, Causes, and Relationship to Emotional Health,” by S. Pflanz and S. Sonnek, 2002, Military Medicine, 167, 877-882.

Arguably, this Air Force study is not completely compatible with the Marine Corps. One notable difference that may reflect somewhat different findings relates to the preponderance of, especially young Marines, finding themselves in a war zone as opposed to the Air Force personnel.

Despite the somewhat surprising findings related to non-combat related stressors, other research certainly presents current problems associated with newer forms of combat, such as in Iraq. Researchers predict that 25 percent of those on the front lines will experience combat stress (Corbett, 2004). However, almost anyone in combat areas now have the same dangers that were previously associated with only the front lines. There are no front lines in operations in a heart of a city such as Baghdad.

Changes in the medical field also exacerbate stress level that service members experience. In Corbett’s article The Permanent Scars of Iraq, he presents the case that mutilated bodies that would expire in any other war, are now salvaged due to technology (i.e. newer body armor) and major medical advancements. The bodies are kept alive but with damage to head, limb, and organs that will present a new face to injured veterans. One surgeon working in Iraq, LtCol Robert Carroll, stated that “We’re saving more people than should be saved probably” (Vick, 2004). Likewise, the invisible scars, the damage to the psyche, are many.

It is with these new findings concerning stress, combined with the recent reports of stress and its relation to Marines in Iraq (Myers, 2003) that prompts the separate issue of stress to be listed as a reason for continued progress and attention to be directed toward Mental Health services.

2. Attrition

Attrition is another area of concern as it relates to mental health. Gunderson and Hourani have been tracking mental illness and its effects on the Naval Service for some years (2001). They have concluded that over time, not only has mental illness been a cause of hospitalization in the Naval Service, but it is also a major cause of premature attrition. The Marine Corps has defined premature attrition as Non-End of Active Service (EAS) attrition, in other words, being discharged prior to completion of a designated number of years listed on a service contract.

Hoge, et.al conducted a study spanning the four military services in the 90's and found even higher rates of attrition. A few of the pertinent results follow:

- Mental disorders were the leading category of discharge diagnoses among men and the second leading category among women.
- Thirteen percent of all hospitalizations and 23 percent of all inpatient bed days were attributed to mental disorders.
- Six percent of the military population received ambulatory services for mental disorders annually in 1998-1999.
- Among a one-year cohort of personnel, 47% of those hospitalized for the first time for a mental disorder left military service within 6 months.

For some time the Marine Corps has examined ways in which to prevent Non-EAS attrition that is costly and makes manpower management more difficult. Fixes have included better initial screening methods/higher selectivity, to putting the onus on leaders to work more with those who are experiencing troubles. Currently, and possibly due to Operation Enduring Freedom (OEF) and OIF, Non-EAS attrition is lower. Recruitment is at an all time high and overall Misconduct discharges are down. However, as Tables 2 & 3 reflect, there are still challenges to be met in ascertaining ways of reducing costly attrition

Table 2 provides a breakdown of historical Non-EAS attrition (Misconduct) from FY 98-FY 03.

Table 2. Non-EAS Attrition Rates/Misconduct

Misconduct	**FY98**	**FY99**	**FY00**	**FY01**	**FY02**	**FY03**
Alcohol	107	102	74	74	68	35
Civilian Offense	15	11	4	8	6	12
Drugs	1671	1487	1610	1696	1970	1227
Homosexual Conduct	62	73	85	80	68	40
Minor Disciplinary Infractions	195	180	118	80	69	34
Patterns of Misconduct	443	470	516	434	519	445
Sexual Perversion	0	5	0	2	0	0
Deserter Separations	210	228	8	0	3	1
Unauthorized Absence	9	12	12	9	7	11
Other*	1511	1135	842	1111	908	147
Total Misconduct	4223	3703	3269	3494	3618	1952

Note. From data provided by Headquarters Marine Corps. *Other includes court-martials for unspecific reasons, reduction discharges, and separation in lieu of court martial.

Table 3 provides a breakdown of historical Non-EAS attrition (Other categories) from FY 98-FY 03.

Table 3. Non-EAS Attrition Rates/Other Categories

Other Categories	**FY98**	**FY99**	**FY00**	**FY01**	**FY02**	**FY03**
Death	76	95	96	71	103	120
Convenience of the Government	1367	1461	1434	1228	1168	1298
Physical Disability	1898	1286	1008	972	914	924
Unsatisfactory Performance	205	156	113	125	102	89
Deserter Status	1050	1187	1627	1647	1347	1096
Total Attrition*	8819	7888	7547	7537	7252	5479

Note. From data provided by Headquarters Marine Corps. Data from FY03 does reflect a reduction in discharges due to operations in Iraq and Afghanistan.

*This includes the numbers for misconduct in Table 2 above.

The importance in presenting the preceeding Misconduct cases as well as some of the other reasons for attrition, i.e. “Convenience of the Government” discharge (which includes some degree of mental health cases as does the “Physical Condition, Not a Disability” discharge) is important. Many of the Marines discharged with Misconduct categories had concurrent mental health problems that could

have been treated at one of the various mental health facilities that the Marine Corps offers. Less significant mental disorders, i.e. adjustment disorders are listed as Axis II level disorders under the Diagnostic Statistical Manual (DSM) IV.

The Marine Corps' Separation Manual states that Marines with Axis II level disorders must be allowed to be treated over time, allowing the Marine an opportunity to improve, before discharge proceedings begin. The exception to this rule is when the Marine may pose a threat to him/herself or to others. Due to misconduct or other reasons, however, a Marine in this category has another basis that allows for the beginnings of an administrative discharge package and ends up being discharged on the basis of Misconduct rather than a mental illness that may be a concurrent. This process makes it difficult to track mental illness strictly through attrition statistics.

It is reasonable to speculate then that a portion of the Misconduct cases are also Mental Health cases or would be in the absence of other circumstances/discharge basis. In fact, an Army study in 1986 (Grunzke, Schroeder) associated certain attributes of Infantry Trainees who attrite as similar to those who may have misconduct problems should they stay; there is a relation, although how much is unknown. Interestingly, although substantial counseling was provided in the previously mentioned research, the study reflected an attitude by those that were discharged that personal and professional counseling, to include feedback, would have been beneficial in potentially preventing their discharge (pg 21).

3. Suicide

For some in mental distress, one way out is to end their lives. Although there is considerable debate over whether increases in military stressors create an environment in which suicide rates are higher, in what is overall a considerably healthier population than non-military settings, the fact is suicide does happen. Recent news articles (Labbe, 2002, Beaumont, 2004) covering IRAQ give the impression that suicides are increasing in the military.

Dr. William Winkenwerder, the Assistant Secretary of Defense for Health Affairs, provided information that reflected an increase from 10.5 to 11 deaths per 100,000 Army personnel to 13.5 per 100,000 deaths beginning with the IRAQ war (Observer, 2004). This reflects a 20% increase. However, when the average suicide rate for the national population is 15.10 per 1000,000 (Holmes, 1998) the statistics do not look so disparate. Maze lists the average suicide rate for the national population even higher than Holmes at about 20 per 1000,000 (2004). Maze states that overall, regardless of specific service, “suicides in the military generally range between nine and 12 per 100,000 people” (pg 1). As Table 4 reflects, all the services, to include the Marine Corps, average below the national averages in suicides. In fact, considering that there are significant stressors in military life not present in the civilian life, similar or lower rates than the average general population may seem a positive statistic.

Notwithstanding the above statistics, many would say that in a generally young, educated, healthy military

population with “access to comprehensive medical care” (Hoge, 2002) the suicides numbers are too high. Table 4 reflects historical suicide rates by service. In order to present these percentages in actual deaths, the following information from Holmes’ 1998 study is provided: “On average, 232 men and 11 women in the military commit suicide each year.” There are approximately 1.4 million people in the military service.

Table 4. Service Suicide Rates by Year

	90	**91**	**92**	**93**	**94**	**95**	**96**	**97**	**98**	**99**	**00**	**01**	**02**	**03**
Navy	9.5	10.2	11.8	11.0	12.	17.5	10.7	10.7	14.4	11.0	11.7	10.4	11.3	11.7
USMC	18.3	12.3	14.0	20.9	14.3	19.5	16.7	11.7	12.3	15.0	13.9	16.2	12.6	12.6
USAF	10.0	13.0	13.8	13.1	16.4	15.8	12.4	12.1	9.4	5.6	8.4	10.4	8.3	9.9
USA	13.5	14.4	14.3	15.7	14.8	14.8	12.4	10.6	12.0	13.1	12.1	9.1	10.9	11.6

Note. From an editorial on Spartacus.com, which contained data from a presentation made by Col Thomas Burke, MD.

Separately, the following suicide data (from 2003 only) from operation Iraqi Freedom reflects service differences:

- Army
  - 18 confirmed suicides
  - Suicide rate 13.5 per 100,000 soldiers
- Marine Corps
  - 2 confirmed suicides
  - Suicide rate 5.3 per 100,000 Marines
- Navy
  - 2 confirmed suicides in forces supporting OIF
  - rate not available because of small onshore presence

- Air Force
    - No suicides in forces supporting OIF

Although the Marine Corps' numbers were very low during Operation Iraq Freedom (OIF), studies reflect that "while suicide is a relatively rare phenomenon statistically, it is the third (12-13%) leading cause of death in the U.S. military" (Holmes, 1998). The two highest leading causes of death were unintentional injury (61 percent) and disease (20 percent). Holmes' study further indicates that the Marine Corps, over a 13 year time period, had the highest rates of all the four services (pg 8). This is partially due to the younger (on average) Marine Corps personnel. These suicides are preceded by emotional distress. Every day problems (not associated with mental illness), work and relationship problems, health, and financial problems are typical. And these are typical problems that counseling can help.

When Admiral Boorda chose to take his own life in 1996, the issue was raised whether military personnel felt comfortable in obtaining mental health services (Becker, 1997). Past studies (McCarroll, 1993) indicated that they did not, for fear of many things to include a fear of a detrimental impact on one's career (16 percent of self referred respondents felt this). One military member who committed suicide in 1990 left a note behind with that exact message, " . . . he feared seeking help because he feared its impact on his career" (Becker, pg. 25). Other fears/area of concern of self-referrals that McCarroll (1993) found follow:

- Didn’t know where to go for help (16 percent)
- Afraid to ask for help (24 percent)
- No one cares (15 percent)
- Fear of disclosure (9 percent)

So, although there is controversy over whether suicide numbers are that much different in the civilian population, it is a concern that more personnel do not seek treatment when resources are readily available. The question that many ask is whether suicide rates in a very healthy population could be reduced if mental health resources were taken advantage of to a greater degree.

C. RELATIONSHIP BETWEEN PSYCHOTHERAPY AND MEDICAL UTILIZATION RATES

Studies in the civilian sector that discuss the relationship between medical utilization rates and psychotherapy abound (Holden & Jones, 1995). These studies have long shown that an increase in psychotherapeutic use, decreases medical utilization. The Air Force’s first pilot study to attempt a military replication of similar studies had very similar findings (Planz, 2002). Although the researchers were aware of sample size limitations of the study, they nevertheless thought the results important enough to recommend further study.

The important issues involve more than the potential cost savings that the military may realize. What this and other studies have found were high degrees of medical use (outpatient visits) for psychological problems. The following findings, synthesized by Jones and Holden (1995), illuminate this problem area:

- Estimates of psychiatric disorder not presented as such, but judged to be severe enough to interfere with optimal care in the general medical setting, range as high as 50 to 80% of all patients.

- It has also been noted that 60% of all primary care medical visits are for psychologically based complaints.

- Primary care physicians, generally the first point of medical contact for patients with behavioral and emotional problems, estimate that as much as 50% of their time to be spent dealing with psychological rather than medical problems.

- It stands to reason that mental health professionals who have the training and the time to deal with such problems should be able to do a more effective and cost-efficient job of treating them, as well as freeing the primary care physician's time for more appropriate tasks.

Earlier findings synthesized by Nice (1982) also follow:

- In a study of five fee-for-services, general hospital clinics, . . .reported that 22% of routine medical patients had an emotional disorder.

- A twelve-month retrospective survey of outpatient records in a family practice clinic identified psychosocial problems in 33% of the adult clinic population.

- . . . found emotional disorders in 51% of the medical patients surveyed and no evidence of organic disease in 38%.

- The over-utilization of medical hospital services by individuals who have mental conditions "masquerading" as physical symptoms could amount to as much as $10

billion per year for misdiagnosis and ineffective treatment.

A San Diego Naval Health Research Center study, conducted in 1982 (Nice) reflect similar findings but with the population being Navy and Marine Corps personnel, specifically. The study reflected a marked increase in women and older individuals who were seen in outpatient clinics for psychological reasons, but overall, the study found 23% of total clinic visits which would have more appropriately been scheduled with a mental health provider. This study attempts to show the universality of the mental health problem in the civilian and military sector. Also, it attempts to point out when appropriate that various studies show conflicting high use populations. Consequently, regardless of population demographic, need throughout the population exists and targeting of underlying causes and needs should be better scrutinized to filter patients into appropriate healthcare specialty areas.

D. MENTAL HEALTH SERVICES AVAILABLE IN THE MARINE CORPS

Other than the work that is concentrated on reducing suicide, attrition, and stress, care is taken in updating and refining available medical services. The healthcare that active duty service members receive is free and available at anytime. The military medical healthcare system has changed dramatically from years past. But, as much as TRICARE and other related changes have evolved, studies reflect that as the system advances, concurrently misuses remain the same. An explanation of this concept is discussed below in the healthcare section. The separate services that have been developed to fill some of the gaps,

which may also help in the mis-use of the medical system, are also discussed in this subsection.

1. Counseling Services

Mental Health Services in the Marine Corps are provided through various specialized service areas, to include the Substance Abuse and Rehabilitation Program (SARP), outpatient Psychology Services, Psychiatric Centers in Navy Medical Centers, and Fleet and Family Service Centers, and Marine Corps Community Services (MCCS). This list is not exhaustive, and does not include the services available through TRICARE for family members and/or family treatment apart from individual counseling of active duty Marines.

2. Semper Fit

General Krulak, former Commandant of the Marine Corps, was instrumental in making sweeping changes in services that promoted healthy living, to include mental health as well as physical health. Semper Fit, under the MCCS program is an outcome of many changes and advancements in the Marine Corps Personal and Family Readiness programs.

It was under General Krulak's tenure that the focus of services shifted from treatment and intervention services to prevention ("Personal and Family Readiness," 1998). Some methods that he promoted were deglamorizing alcohol ("Semper Fit Alcohol Abuse Prevention and Deglamorization Campaign," 1997) and Suicide Awareness. An eventual outcome of practicing prevention was monthly Health Promotion messages which were available Marine wide. The themes each month ranged from Heart Health to STD's. Mental Health was the theme one month ("May 2002 Health Promotion Month," 2002).

Although the current MCCS has a variety of areas it concentrates on to include Marine Corps Family Team building, the Single Marine Program and Personal Services, the Semper Fit area practices multiple methods in individual fitness and health promotion. Counseling services are a part of the program. To this day, however, a prime focus remains on the problems of attrition, problems present during General Krulak's time in 1997 and 1998. The "fix" seems difficult to combat. And the cost of not having a better "fix" is an estimated loss of $983 million yearly or the "manpower burden equivalent to **TWO INFANTRY REGIMENTS**" ("MCCS website," 2004).

3. OSCAR Program

In June 2003, the Marine Corps initiated a pilot program ("Division Order," 2001), which consists of unit organic multidisciplinary teams of military providers, providing support during all phases of deployment through proactive management of operational stress and related mental health problems. The pilot initiative is titled the OSCAR (operational stress control and readiness) program. Part of this research study was not only to ascertain some of the functions within the program but to introduce the possibility of destigmatization training within the OSCAR program services, which would include information on available mental health services.

With greater knowledge, through training and education, this problem of lack of awareness could be reduced. Further, increase in awareness would alleviate some amount of stigma. The civilian sector partially combats stigma through various campaign plans, which include, "education, research, awareness, and advocacy"

(Bradley, 2002, p. 81). In this respect it is worthy to measure whether the same improvements should be sought in the military setting. This particular program will be discussed in greater detail in Chapter V.

E. CHAPTER SUMMARY

This chapter presented a broad view of the most pertinent issues which mental health services may assist with, stress, attrition, and suicide. It also presented another problem area within the overall health care system, that of outpatient medical use that would be more appropriately serviced by mental health service providers. Lastly, current services available were presented, as well as the latest programs, to address stress, attrition, and suicide, and stress were presented in the form of Semper Fit and OSCAR.

Stigma could be a possible detractor from Marines utilizing the services, however. As will be suggested several times in this study, a “fix” may not be to add another program but to first ensure that Marines are taking advantage of the current programs. Gen Krulak had a sense of some possible barriers to seeking help when he stated,

> To begin with, leaders must destigmatize treatment for emotional problems; seeking help is not a sign of weakness, but rather a responsible action in coping with a difficult situation.

The proceeding chapter addresses the stigma associated with the use of these and other mental health services.

III. MENTAL HEALTH SERVICES STIGMA

A. INTRODUCTION

The website for the National Mental Health Awareness Campaign states the following:

> Mental health is extremely important in the adult population. An estimated 44.3 million of American adults suffer from a diagnosable mental disorder each year. Approximately 18.8 million adults have a depressive disorder and over 19 million adults suffer from anxiety disorders. Millions of other people are dealing with bipolar disorder, schizophrenia, eating disorders, substance abuse and other mental health problems. Mental illnesses can cause a person to have major difficulty functioning at their job, as a parent and in all areas of their lives. It is imperative for adults to be aware of their mental health and the mental health of their loved ones.

Rabasca (1999) considers the biggest treatment barrier for people in the above group as stigma. There are myriad definitions of stigma, but Wahl (1999) suggests that "the common feature of most definitions of stigma is that all of them suggest in one way or another that stigma involves disvaluation of person." And, in fact, the National Campaign is committed to just that cause, combating stigma, which may increase mental health services utilization rates.

This chapter will provide a broad overview of the relevant and most current literature regarding stigma. It will address stigma in the civilian sector prior to presenting more specific information regarding stigma in the military sector. Like the assumed compatibility of the civilian studies, non-Marine Corps specific military studies will be presented with the assumption being that in

all cases there are more similarities than differences within the populations. Certainly, as discussed in the previous chapter, military members are viewed as possibly being more Type “A” and Type “A’s” are more prone to have negative psychological and physiological effects from stress (Friedman, Rosenman 1974). However, as a cross section of society, the personnel within the military and the Marine Corps, specifically, are just that, a representation of society. This chapter will cover the stigma in the military more deeply though, with greater emphasis on the information from military studies, to include non-U.S. military studies.

B. STIGMA IN THE CIVILIAN SECTOR

There was once a stigma associated with having cancer, until more was learned about the disease and its prevalence realized. Like cancer knowledge, mental illness knowledge, even by the average citizen, has increased over time. The link with biological and neurological factors would presumably lessen the characterological deficits previously associated with many mental illnesses. Nevertheless, books, such as Telling Is Risky Business by Otto F. Wahl (1999), present a very strong societal stigma regarding those with a mental illness.

Researchers have attempted to discover what the mental illness fears are exactly. One study, discussed by Corrigan and Lundin (2001) found three attitudes or stigmas directed towards mental illness by average citizens. They are:

1. Fear and exclusion: persons with severe mental illness are dangerous, should be feared, and therefore, be kept out of most communities

2. Authoritarianism: persons with severe mental illness are irresponsible; their life decisions should be made by others.
3. Benevolence: persons with severe mental illness are childlike and need to be cared for.

Another study, discussed in Wahl's book (1999), found that a psychiatric label, regardless of type, garners a similar negative stereotype or stigma associated with it. Even outpatient clinics servicing those with more mild problems such as marriage and family issues contained clients that are reluctant to seek treatment or let it be known if they had.

Depression is one particular mental illness that is often cited in the literature as in need of attention. Windham (2003), writing about a recent national study conducted by Harvard Medical School researcher Ronald Kessler, wrote that 33-35 million adult Americans suffer from major depression in a lifetime. This is about 16.2% of the population. It indicates an increase from the previous decade and the good news is that the increase is accounted for by the lessoning of stigma, i.e. more people report. However, the bad news contained in the study is that the care given is inadequate.

A letter to the editor concerning the above findings was less positive. Michael M. Faenza, President and Chief Executive, National Mental Health Association, wrote that "Mental illness remains under-diagnosed and under-treated because of stigma and the lack of coverage and access to care" ("Letter to the Editor," 2004). Another article cited major depression as a leading cause of lost workdays

(Elias, 2003). Windham (2003) goes a step further by stating that the "annual cost to employers for absenteeism and other loss of productivity by depressed workers is estimated at $44 billion."

Depression is certainly not the only mental illness associated with stigma. In general, mental disorders as a whole do not get treated due to "shame and trouble paying for care" (Health Wellness, 2003). This finding was from the first Surgeon General review of research in 1999. A more recent review presented a contemporary perspective by the commission:

> Little about the nation's mental health system has changed since then, and the commission cites stigma surrounding mental illness as a major barrier to treatment.

In response to this report by the presidential commission, which was created in 2002 by President Bush, a recommendation was made to basically overhaul state mental health care systems (Health Wellness, 2003).

C. STIGMA IN THE MILITARY SECTOR

The military population is said to be a reflection of society. With this in mind, the applicability of the civilian studies to the military is obvious. However, although the above data may be sufficient in portraying the prevalence of mental health illness and associated stigma in the public sector, it may be beneficial to present separate military studies.

1. U.S. Military Studies

The previous chapter contained much information that depicted the vast number of both civilian and military personnel with mental illness. Likewise, it presented the fact that there are numerous services available to assist

in dealing with the emotional problems, distress, mental illness, or stress that reduce life satisfaction and work performance. The contention of this section, based on findings contained within the literature is that there is help out there, but many of those who need the help are not taking advantage of resources. The literature suggests that one reason is stigma.

The stigma of mental illness in the general population has existed from the beginning of time. Becker (1997), who studied mental health in the U.S. military, stated that we have advanced enough to understand that all those with mental illness are not psychotic or "crazy" but so many still believe mental illness as being a character weakness. And who especially does not align themselves with the idea of weakness, the military, many contend. The military, that Becker and Becker (1997) states is a culture that promotes the uniqueness of the "macho warrior" (pg 24).

One interesting study that looked at the emotional component of medical utilization rates found lowered rates of psychosomatic visits from Marine Corps and Naval Air Station personnel than the general military population without being able to explain why. The possibility was mentioned that the clinics which were in low-population areas were less likely to have psychosomatic visits than those in urban areas. The study however, surmised that the active duty and dependent population from their study "may be less inclined to visit medical outpatient facilities for social or emotional reasons than other Navy groups" (Nice, 1982). This could potentially be an area where the association to an elite force drives the de-stigmatizing effects that go along with that force. Although the

explanation from the study is not clear, the findings are nevertheless interesting. Table 5 reflects some of the findings, which reflect the various differences among the two services.

Table 5. Diagnostic Classification Most Frequently Associated with Outpatient Visits Precipitated by Social or Emotional Factors

DIAGNOSIS	NAVAL AIR STATION	MARINE CORPS
DEPRESSION	146.66***	64.15***
ANXIETY	102.28***	92.40**
OBESITY	41.65***	4.88*
IRRITATED-BOWEL SYNDROME	19.34***	5.04*
FATIGUE	13.60**	4.40*
PEPTIC ULCER	9.90**	6.12**
ABDOMINAL PAIN	8.29**	NS
HEADACHE	8.29**	5.72**
HYPERTENSION	8.17**	NS
DIARRHEA	4.37	NS

Note. From “The Contribution of Social and Emotional Factors to the Utilization of Navy Outpatient Medical Facilities,” by S. Nice, 1982, Naval Health Research Center, 82-4.
Significant at *p< .05, **p< .01, ***p< .001, NS =not significant.

Of the over 800 personnel in the above study, the listed numbers reflect that “approximately 23 percent of all medical outpatient visits were precipitated by social or emotional factors” (Nice, 1982, p. 2). Additionally the numbers reflect the possibility of truth from the previously discussed issue of the possibility of elite forces underutilizing services; which Table 6 reflects in the lower number of diagnoses in those treated at a Marine Corps site (considered more elite) than those from the Navy

site (considered less elite). Nice furthers the discussion by commenting that the 23 percent found in this study is conservative when compared to comparable studies in the civilian sector, which reports nearly 60 percent of medical outpatient visits that are really psychological issues. These studies lend credence to the idea that psychological services are probably underutilized in preference for medical visits, which may maintain a self-perception of strength in fear of feeling weak.

Dr. Kutz, a military psychiatrist, was quoted in Becker's (1997) study as saying:

> Like other minority cultures, the military places great stigma on mental illness . . . it is well known in the military psychiatric field that people shun care. He explains that commanders will often choose to avoid care, "for fear that his troops will view him as weak and lose confidence in his leadership. The sad fact, however, is that no educated person in today's society would seriously question the widespread existence of mental illness in a wide cross-section of society.

So what are the specific reasons/fears that Marines have that prevent them from taking advantage of available mental health services? Aside from the fear of career loss and the perception of weakness, confidentiality and privacy appear to be mentioned the most (Johnson, 1995).

Confidentiality is definitely a concern that is also present in the civilian sector. Even a recruit in boot camp is told it is his/her (or any other active duty members') obligation to report offenses under the Uniform Code of Military Justice (UCMJ). So, although not fully cognizant regarding issues of privacy and confidentiality, they *do* have a gut feeling that what they say becomes a

point of record with their therapist. It is not simply the social stigma associated with getting help that detracts from taking advantage of services, but others knowing of the root problem (ARI, 1986).

The dual role that a practitioner possesses is also an issue with many potential mental health patients. Although numerous studies cite this problem as a major issue for practitioners as well (Johnson, 1995), Marines also are troubled by the dual-role that practitioners hold. They are hesitant to believe that a mental health provider has their best interests at heart when the commanding officer referred him/her to the practitioner.

Johnson (1995) presents a strategy that practitioners in the past have used to favor the professional over the military role. The strategy involved “avoiding violations of confidentiality by way of absent or sparse documentation in records” (pg 284). The strategy that many military members use to protect their privacy and avoid dual role conflicts is to abstain from disclosing material that would otherwise be pertinent and beneficial in the therapeutic alliance and the overall success of the therapy. In a separate study, Johnson (1994) listed purposeful misconduct, i.e. removal of Mental Health consults from medical records as a practiced solution to ensure privacy.

2. Non-US Military Studies

The Marine Corps, and in a broader sense, all the U.S. military services, are not unique in studying and showing concern over the mental health of its service members. Other countries are tackling the issues of stress, utilization of services and stigma as well. A London-based naval editor concluded, “Navies are coming to realize the

need for improved upkeep regimes to address the toll that operations may take on their most important assets-people" (Scott, 2002, p. 1). Mental health issues in the military appear to be universal.

A study of Greek Warship Personnel (Mazokopakis, 2002) found mental disorders as the main reason for early discharge. Although Marine Corps statistics reflect the categorization of misconduct as having the largest Non-EAS attrition rates, similarly to the Greeks, mental disorder discharges are also high. Additionally, as stated earlier, there certainly appears to be a linkage between misconduct and mental disorders.

The Hellenic Navy study also found considerable adjustment problems that were seen as symptoms of the mental disorders. Because many personnel are conscripts it stands to reason that some adjustment problems are due to major lifestyle or value differences that are not commensurate with a military way of life. Regardless, the study was critical in looking at all angles and pointed out that " . . . an appeal of a psychiatric diagnosis is a well-known way of obtaining a premature discharge…" (Mazokopakis, pg 883).

Similarly, as discussed in the previous subsection, the U.S. Marine Corps also sees many adjustment problems in those that want to be in the service. Likewise, the Marine Corps probably shares a track record of administrative discharges for psychiatric diagnoses prompted by the Marine who desires a release from his or her contract. This certainly adds a degree of difficulty in looking at and determining the veracity of utilization rates.

A potentially important finding not specifically pointed out in many other studies is the cycle from low-education level to somatic problems (Mazokopakis, pg 887). Although it may appear to be intuitive that younger personnel may naturally have less education, the idea that many who are less educated express psychic problems in somatic forms, furthers the cost effectiveness of education to reduce military health care costs. It would be rational to emphasize the younger audience in any type of education or training program. Nevertheless, as pointed out in several other sections, the target population should be everyone overall, regardless of age, rank, marital status, gender, etc.

One of the problems that is clearly evident in the literature regard stigma. The UK author, Scott, (2003) spends considerable time delving into reasons why military personnel do not feel comfortable seeking counseling services. The stigma associated with obtaining help pertains to “a failure of their manhood.” The strength associated with those who may serve in the military profession negates the frailness and fallibility of all persons in crisis situations or while under extreme stress. The article points out that it actually requires much strength to ask for help. Although there is a more modern “macho” image than in days of old, as with all major shifts in roles and perceptions, it takes a tremendous amount of time to update fully.

Other than the stigma associated with a loss of manliness, a fear of jeopardizing one’s career is another element of avoiding counseling treatment. This is no different than U.S. personnel fearing a breach in privacy

or lack of confidentiality etc. This can be crucial in the Royal Navies' personnel in determining whether to seek treatment or deal with one's problems without external help. The UK's military considered contracting mental health services out as a means of reducing the military connection that worries so many.

Scott (2003) also lists Australia as a country recognizing the need for more attention to be directed toward the psychological component of the maritime combat environment rather than just the physical. Senior military members are pushing for a proactive rather than a reactive stance in awareness and education.

3. Cost of Stigma

The stigma associated with using mental health services produce great costs on the individual and the organization/unit. The previous chapter listed many significant negative outcomes to include attrition and suicides. Many lesser burdens are equally crippling when thought of in whole. Individually, Johnson (1994) listed avoidance of care and seeking civilian care a cost of the stigma associated with military counseling. Also, stigma can lead to increases in already present stress due to a feeling of no way out or hopelessness.

Organizationally, the morale of units can be negatively affected by personnel with poor mental health. Mental illness and its complexities, like pessimism, have a cancer-like effect. Performance and effectiveness is lowered. Others, coming into contact with an ill, untreated Marine, may perform at a reduced level as well. Good order and discipline can be affected. High levels of medical utilization (vs. appropriate mental health care

utilization) produce high rates of absenteeism. These rates of absenteeism are compounded by a lack of abatement of psychosomatic illnesses that would otherwise be properly treated if the correct services were utilized (Nice, 1982).

D. CHAPTER SUMMARY

This chapter presented the argument, based on a literature review, that stigma associated with utilizing mental health service exists. Both the military and civilian sectors have room for improvement in this important area. Stigma found in other countries and other countries' military forces was also shown to exist. If stigma is not reduced, continued negative outcomes on individuals/Marines and organizations/units will persist.

IV. DATA ANALYSIS

A. OVERVIEW

This chapter presents excerpts from the three interviews and an analysis of the interview data. It also presents a review of the Operational Stress Control and Readiness Program as well as a review of various National civilian destigmatization programs.

B. PRACTITIONER INTERVIEWS

Three practitioner interviews were conducted to answer one of the two primary research questions:

Do mental health practitioners perceive a stigma associated with the use of mental health services in the Marine Corps?

Each practitioner was chosen because they were either currently attached to a Marine Corps command or had previously been attached to a Marine Corps command. The following interview results are presented:

1. Fleet and Family Service Center (FFSC) Counselor Interview

The FFSC practitioner interviewed had over 17 years experience working with all the military services, but primarily with personnel from the Navy and Marine Corps. The experience that he had working with civilians was limited to civil service employees and civilian spouses/children of active duty or retired military members. He is a Licensed Clinical Social Work Counselor (LCSWC).

When asked about any differences, between military and civilian persons, regarding hesitancy to see him, he replied:

> Probably, there's a bit more reluctance, but I would guess that it's not terribly significant. What I have found, for example, I'll just check my records from time to time. And over the years about 40% of my clientele has been officer or officers' families. And about 60% enlisted. That's kind of interesting, because a lot of people, especially at the Academy, I have found assume that we're here to serve enlisted. And they're always quite surprised when I say, oh, well, 40% of my -- my clientele is officers. But it matches what you see in the general population. College educated people are much more likely to turn to therapy than people who are not. So I think that probably the percentages are about the same, civilian and military both.

When asked what specifically about college educated persons made them more amenable to seeking therapy he said it was more than education:

> . . . and willingness. I think it's more a matter of attitude, that they're more likely to be accepting of it and that there would be less stigma attached to it the more education they have. Just in terms of general knowledge, we run newcomers programs for everybody that comes in the base here. Anybody who comes on board here has to check in and check out with us. The knowledge is there. They've heard of it. And the Navy, in general, and the Marines in particular too, what I find is with the enlisted that if their LPO, if their petty officer or if their chief or platoon sergeants or whatever are -- are familiar with it, they have a good opinion of it, then the recommendations are going to come in and I'm seeing a lot of enlisted people. But if they're not there, then I don't see that many enlisted people.

As the interview segued into the discussion of the role of leadership in establishing a safe haven for Marines to seek treatment, he presented this anecdotal story:

> Essentially, the previous gunnery sergeant we had here was somebody who was open to the idea of counseling. I had a chance to work around some family issues with him. And it seemed to go very well. I was also getting many referrals through him with lower enlisted men. Since the gunnery sergeant left, I've had virtually no referrals from the Marine guys here. It's a major difference. It's very noticeable. And, you know, I was introduced to the new gunnery sergeant and tried to chat him up a little bit, but simply have had no inquiries, no interest and no referrals.

The practitioner was additionally asked if Commanding Officers (CO's) specifically were prone to treat their Marines' therapy in a positive or negative light. He suggested that in a way he was limited in knowing how the Marine (client) himself perceived his CO's perspective. He had this to say:

> Well, in 18 years I've seen at least six, maybe seven, CO's come and go. I can name two or three of them who were very actively interested and had a very positive opinion of it. And I would hear that reflected in the Marines I was talking to. There were a couple three others where I was not getting near as many referrals. But I wouldn't be hearing negative feedback, even though I would be having an occasional Marine come in here. Partly, they were -- they were reluctant to say something negative about command, in the first place. And partly, they simply wouldn't know if the negative attitude is there. The people who were coming in were coming in because the wife insisted, because they had had previous counseling experience themselves. They talked with somebody that had a positive experience laterally. But if there was negative attitude, I've never had much explicit evidence of that. But I would definitely see a difference in the people.

Because the literature suggested multiple barriers to seeking treatment, i.e. lack of confidentiality, lack of privacy, loss of job, the practitioner was asked if any of his clients voiced these same concerns. He expressed the following:

> I haven't heard much of that, because practically the first thing I do when I talk with anybody is review the Privacy Act that they sign, ask them if they have any questions and explain how we handle confidentiality. And most of them seem pretty straightforward about that. I may have had one or two who worried that -- they would express worry that, oh, this might affect my chances for promotion or whatever. And I've always been able to say, my experience has been that it's not going to. And, in fact, generally, in the Navy, officer (indiscernible) -- and in the Marines, there have been a number of situations where it might be seen as a positive. If somebody is having marital trouble, they go in and they work on it in marriage counseling, (indiscernible) the problem is cleared up. I've seen a number of situations where that was viewed very positively by command.

When asked about whether stigma may be less important than lack of knowledge, he emphasized that multiple factors, to include leadership tones, play a role in whether treatment is sought. He expressed that his experiences with the above come second hand such as the story that follows:

> I have heard anecdotal stuff from both the Navy and Marines. And some Marines, in particular, that this sergeant or maybe a lower enlisted or whatever would make very discouraging remarks about counseling. And they would reflect just generally what you'd expect from the population. People who aren't familiar with it are suspicious of it. Yes. That does exist. Yes. It is communicated, particularly with the youngsters

> coming in, the lower enlisted. If there is somebody at the officer level who says anything positive, then it's much more likely they will pursue counseling.
>
> So, yes. There is some stigma out there. I don't have much of a way of reading, because most of the people who hear these stigmatizing remarks (indiscernible) again, the lower enlisted, are just not going to show up in my office. So the people who are most affected by the stigmatizing are the people who are most likely not to come in. So the evidence I can offer back to you is anecdotal. It is there enough to know that, in fact, that many of the people I've talked to have heard direct negative comments from their superiors.

The FFSC practitioner was asked about any expressed preferences on the part of clients, whether they preferred a counselor of a particular sex, ethnic background, specialty, etc.

> The most likely one is if I have a woman Marine who calls or who stops by and talks to me. And I will always ask her, would you rather talk to a woman or a man? And I couldn't put a percent on it. There are a few who will say, yes, I really would much more like to talk with a woman. And I never ask them, but I always figure, well, maybe there's some sexual abuse in the background and whatever it may be.
>
> But I also have had many say, oh, no. I -- I just want to talk to somebody professional, or if they've walked in and they spend five minutes with me, I feel like I can talk with you. And I have worked with many women who, in fact, were incest survivors or whatever and it seems to settle down very quickly. But beyond that, I have had people come in and say, well, I've heard -- I've heard about the family support center, but you're just more practical. You -- you work closer with us and you also are a civilian. The Hospital Point, they actually have a small mental health division there. And usually, the military

> people on their staff are officers. So sometimes that's seen by a few people as a barrier.

Considering budgetary and manpower issues that are always considerations in adding some form of training to what a Marine receives, the practitioner was asked whether a form of destigmatization training would be worthwhile. He related the following:

> Well, my first career I was a college professor. And my quick reaction is I'm not sure classes would be that valuable. More than likely, either a briefing or even a General Military Training (GMT).
>
> But the Marines I talk to in general, probably they come from backgrounds where there is some stigma attached to them. I'm thinking of the lower enlisted here. But, generally, I would think that a whole class, several sessions, would probably be overloading it. And you'd run the risk of turning them off, because they don't see -- you know, Marines tend to be concrete. They tend to be task-oriented. And I think that after two or three sessions they would be uneasy. I would say that yes, there are limitations on how much knowledge is out there. Probably, the average lance corporal, if you asked him about counseling, he may be more likely to fall back on jokes that he heard in high school about shrinks than any particular experience, unless they've actually had a family member or friend who's been through counseling. So, yes. I would think there's a definite need for something like that being presented to all Marines. And any newcomers' indoctrination they get and any base they go into should be repeated. Yeah. I think that would be very valuable.

In suggesting an angle of approach of an educative training, he replied,

> Maybe not a full GMT, but certainly, a one-time presentation. And one thing I think I would do, I've had some training in CISP, Critical Incident

> Stress Management. And they always reach for analogies and parallels with the Oklahoma City bombing, with the cities in the 9-11 stuff with how fireman, policemen, people who do that kind of work, that they have found this to be enormously valuable. My suggestion would be that you approach it from something like that. That Marines have to be prepared to handle stress. And that whether you went directly into talking about post-traumatic stress disorder, or shell shock or battle fatigue or whatever you want to call it, that they should know that stress can get to anybody. They have to be prepared to handle stresses most people never have to encounter. And they should know that it is not un-Marine-like to turn to this kind of help. That's what the chaplains are there for. That's what people like me are here for.

2. Chaplain Interview

The Chaplain that was interviewed had fewer number of years working in the military than the FFSC practitioner. Specifically, he had been practicing chaplain services for the Marine Corps for only two years. However, as a former Marine of eight years, he was very knowledgeable about the Marine Corps as well as had counseled Marines while on active duty as most leaders do. In addition to this experience, he had been a former pastor in the civilian sector.

When asked initially if he perceived a stigma from unit leadership in regard to a Marine seeking therapy, he had this to say:

> No. I don't believe that the command structure believes that there's a stigma attached to it. And I think that that mainly comes from education knowing that there are certain problems or certain pathologies that people might have. And in the long run, when you can take a Marine who might have a problem and take care of that problem and return him to the command as a good

> Marine, then they have no problem sending someone for counseling or getting people help. It's kind of like there used to be, you know, stigmas around things like alcoholism in the military, in the Marine Corp particularly. And now, people realize that is a disease and we can help people with that. And once we give them the help that they need, well then it can be effective.

He related that the lack of stigma that he perceived related to both the officer and enlisted ranks. He did mention that there were barriers that he considered separate from stigma, to seeking treatment however:

> Occasionally, I do get Marines asking, you know, how will this affect my career? And I can give an answer to that question usually that will satisfy the Marine. Actually, another area of concern, and I'm not sure where this concern stems, but sometimes they have concerns about being put on the medication. Like an antidepressant or some kind of medication that would relieve some of their anxieties. Why they feel that way about medication, they just don't want to take pills, I'm not really sure. But sometimes, they're a little bit leery about that.

The chaplain discussed the preponderance of clients coming to see him strictly based on routine counseling needs rather than religion-based needs. He also answered the question of client counselor preferences below:

> They'll come to me with routine counseling needs that are not associated with religion. Actually, the majority of the people that I see wouldn't fit into that category. One of the advantages to seeing a chaplain is that there is no report that I give to their commanders or to anyone else. You know, that it's an opportunity for them to kind of get a feel for what their issues are and how they might have to deal with them. Any other kind of preference would be along the lines, not so much as me as a chaplain, but how they perceive my effectiveness as a counselor.

When asked whether he saw a need for any type of destigmatization training as annual training, or part of some of the Professional Military Education (PME) classes that the Marines receive he had this to say:

> I think that it's always good to have refresher training to make sure that people have that message that there is no stigma attached to someone getting counseling. Certainly, if we did not continue to give that message, that it could change. That people could begin to feel, you know, there is a kind of a stigma about going to counseling or going to see a chaplain.
>
> So I don't think that there is a problem, right now. But I think that in order to ensure that there's not a problem in the future, then we should continue to tell people, yes, that you know, there's no stigma attached to going to see someone. That you're just going to help yourself. You're going to help your family. You're going to help the Marine Corps. And as long as people continue to realize that, that there won't be any problems.

But, when asked whether the Marines had knowledge of the mental health services in the Marine Corps he relayed this:

> I would say that they're not aware of the different venues through which they can seek (indiscernible) and counseling. Once they identify themselves or are identified with having an issue that needs the help of a counselor, then the different resources are going to be made available to them by their sergeants, their first sergeants, or whoever. The young Marine, I don't think that they're aware of what's available, of all the different resources that are available to them. You know, I'm in a training command. So all you know, we have a lot of students here. When I meet with the students, I meet with them as groups. They come in every week and I tell them, you know, this is what I do and this is kind of the role of the chaplain. But I know

> that they've been given training of that nature before. And it's one of those things, you know, well, I'm not really sure that I'm ever going to need to see a chaplain. And, you know, I don't have any problems. And, you know, I'm just a Marine. I'm kind of invincible. So I think it kind of goes in one ear and out the other. And not until they come across a problem where, you know, counseling is going to be appropriate, and they don't even realize that counseling is appropriate for a particular issue that they have, or they're trying to get help from somebody else, does it really begin to sink in these are all the different resources that are available in the Navy/Marine Corp.

3. Psychologist Interview

The psychologist who was interviewed had been in the Navy for 25 years and had significant experience working specifically with Marines. She also had previously worked in the civilian sector for a number of years practicing psychology. When asked about the differences between the military and civilian clients' perceived stigmas regarding mental health counseling, she replied:

> My experience is that people have an initial hesitancy or reluctance to seek mental health services, because of the presumption of there's something weak in their personality character or (indiscernible). So that hampers their seeking care. So the level of psych ache or psych pain had to be higher in order for them to seek services. And I think that they project it onto other people, that other people would think less of them as they would think less of themselves.

When asked about her military experience with unit leadership and whether there was any negative connotation she replied:

> If the military was the referring source -- now, that's different than the civilian sector. In the military we have the higher probability that

> decline in work performance would be a reason that somebody would come in to seek mental health services. And therefore, the senior person to that military would be aware of decline in somebody and encourage the person seeking help. That often was supportive. I support my subordinate getting help, because that would make them a better productive employee or subordinate. So I saw support on that realm on the part of the senior officer or commanding officer. And it's a (indiscernible) to expect a positive outcome.

As with the other practitioners, she was asked about any differences between officers and enlisted in regard to concerns over seeking treatment. She did see a difference, which she attributed to pride on the part of the officer and fear on the part of the enlisted. Her explanation follows:

> Pride and fear are cousins. Okay. Pride being more of a higher order of defense, if you would. Fear being more basic, if you can think of it that way.
>
> But what -- I think in the military when enlisted come for mental health services, there's a possibility that they are seeking to break their contract. They want out of the service, a lot of the time in the military. Enlisted come there to seek mental health services, not always for resolving the conflict that they might have, but looking for an avenue to be able to break the contract. They don't want the fulfillment (indiscernible) or the obligation. When an officer comes in, it's less often a reason of wanting to break a commitment or an obligation, but one who is dissatisfied with the quality of their life. They want to change that or want something to change.
>
> So in the military we have a lot more enlisted than we have officers, so when you divide a portion of patients, if you would, if you're seeing a lot more enlisted, there's a different disposition that you're looking at. Is this

> person suitable for service? When you're seeing an officer, you have to ask yourself the same question, but it's less intense in terms of suitability. They usually have a proven history of success, and they're generally suitable. They want to stay, but they want to adapt or have a situation adapt to them.
>
> When it's enlisted, they're much younger as a population. They're looking often for another avenue of release from the burden of being in the military. So it's a suitability question to stay on active duty or to separate. They don't have the freedom just to quit their job.
>
> In the civilian sector, when somebody is coming to see you, it's not an officer or enlisted. They're not coming to you to leave their job. They could just leave their job if they wanted to, give two weeks notice. So that population of civilians can become (indiscernible) hesitation, but they want to adapt in some way to what their problems are in their life, hopefully to be different.

Because the Navy psychologist brought up the issue of enlisted Marines obtaining services for the purpose of "getting out," she was asked if the clients had legitimate mental health issues or whether they were "faking it." She gave this reply:

> No. I don't see a preponderance of people faking. You know, they're in that regards, what they may not want to face, whatever the issues are, they're doomed to repeat them, because they want to escape whatever the issue is that didn't get resolved by coming into the military. So now they'll go back home to their paths and still be faced with the same issues. They have the opportunity to face them with the mental health services, but sometimes they respectfully request that they not deal with those issues, because they still want to go back home and not be in the military. So the higher priority is not to be in the military, as opposed to dealing with what the issues are. So they come in with issues, but

> they don’t want to seize the opportunity to resolve them and stay on active duty. It’s what your mother might have said, to cut your nose despite your face. So they’ll say, no, thank you, but no thank you.
>
> That’s off the track from the issue of stigma. They don’t care that there’s a stigma. But that subgroup of people who come in can use the mental health services in ways to be relieved from their contract. That’s not relevant to them.

She mentioned that the subgroup who do not desire separation from the Marine Corps have a fear, not so much of confidentiality or privacy, but of losing their jobs. Thinking of both groups as well as officers and enlisted she was asked about client preferences regarding counselor specifics, i.e. gender, etc. The following unexpected answer revolved around lack of services knowledge over counselor preferences:

> Well, I think the unfortunate thing is more common than a preference is lack of knowing where to go.
>
> I’m going to do a side-bar comment to you here. This morning while driving to work I heard embedded in all the stuff that’s going on with Iraq, finally, there’s reports that Rumsfeld asked for in terms of military mental health services as a result of the sexual assaults. Helen Ann Marie Kimberly at DOD. She was in charge of an eight person investigation. They today came out -- or yesterday, with a 121 page report after interviewing the 21 psychs all over the world, interviewing these people about this issue of sexual assault. Their report now will be taken for action by David Chue, who will have to implement that report, found that the greatest problem like with the 100 sexual assaults in Iraq, and they gave numbers for the last few years of such filed sexual assaults, was the young enlisted females didn’t know what to do. They didn’t know where to go. They were afraid,

> because they're caught up in a system in which you have to report something to your boss. And many types of people who are doing the assaults are people that work with you or they didn't know where to go. So the biggest problem is back to prevention and education.
>
> So back to your question. It's not so much preference in gender, preference type, social worker, psychologist, psychiatrist. Most people just don't know. They don't know what services are available, how to access the services. So as much as we think that we're educating people, what we're finding is, they don't know where to go. So we think it's important to make a distinction between a counselor and a therapist, a social worker, a psychologist, a psychiatrist, a chaplain, fleet family support centers, mental health department. They don't know enough to know where to go. So once you get them in the system, they don't care if you're black, white, male, female, PhD, Masters. They don't know the difference. It's to us to maintain quality of care. That's our job, to get the best of care to our marines and sailors. They don't know enough to know.

Because the psychologist voiced a strong opinion regarding lack of mental health services knowledge, she was asked not only about possible destigmatization training, but about a mental health services awareness class. She indicated that Marines may be getting some form of awareness training, however, there may be peripheral concerns that should be addressed. Her concern follows:

> Yes. And it might be that we are doing that, but how are we measuring the effectiveness of that, as a secondary factor?
>
> The third factor is, the majority of our active duty population are male. And they're young males, 18 to 24 years old. Not too far out of high school. What are the things that we know about adolescence and adolescent boys? When you're in school and they give you a sheet of

> paper to take home to your parents, it doesn't always get home to your parents. Right? It gets folded up, waded in the jeans and washed before it gets given to your mother. Well, we're finding the same thing with the young people that are married. Their 18-year-old wives don't know how to access the system, fleet family support centers, to get what they need, because their husbands, who may be told this, aren't telling it to them. Further, we've got somebody else kept in the dark.
>
> And the family members, the children, of course, we're responsible for them. We don't expect them to know. So the young wives don't -- knowing how to access that there are services available to them.
>
> So where do we need to get the information out? It's at the commissary. It's in the pediatric department. The places that they ask them to get the message to them. Because we can't rely on the active duty member to tell them where to go and how to get help. So GYN departments in hospitals, in our clinics, pediatrics, commissaries. Where are the places that our young people are going to be informed about what is available to them? It's very important.

Lastly, she mentioned that an additional problem area is in the leadership's knowledge.

> So if we know people will know where to go, the second thing that we know is the CO's and XO's don't know what to do. They don't know.

C. REVIEW OF OSCAR PROGRAM

Every war, every terrorist act, and every military humanitarian effort leads to an analysis of process improvements, system/weaponry upgrades, and means of being better prepared to react to events. The USS Cole attack brought to light the sizable number of Sailor evacuations that were accounted for by stress reactions alone. Based on this occurrence, the Department of Defense mandated that

Combat Stress Control (CSC) programs be established. As was discussed at great length in previous chapters, we lose Marines from missions for myriad reasons such as suicide and attrition, as well.

In response to the above DOD Directive and the loss of Marines critical to unit missions, 2dMarine Division began a unique program, the OSCAR program. The program consists of unit organic multidisciplinary teams of military providers, providing support during all phases of deployment through proactive management of operational stress and related mental health problems ("Division Order," 2001). The pilot initiative had undergone a one year assessment within 2d Marine Division, which proved to show positive results, prior to being institutionalized in 2001. The Marine Corps initiated the pilot program at the Division level in July 2003. The two year study is ongoing.

Each trained team member, which includes Chaplains, mental health professionals, and Staff Non-Commissioned Officers (SNCO's) work towards the following mission listed in the Division Order (2001):

- The primary mission of the OSCAR Team is to field a combat ready, deployable unit whose primary mission is to minimize negative operational stress reactions at all levels of the Division by prevention, early intervention, and restoration.

- The secondary mission of the OSCAR is to provide ongoing training and education to all units in operational stress control, Critical Incident Stress Management (CISM), suicide prevention, crisis intervention, and pre/post deployment briefings.

- The tertiary mission of the OSCAR Team is to provide liaison to MCB agencies such as the Naval Hospital, Community Counseling Center, and the Alcohol Treatment Facility (ATF) for the purpose of utilizing and integrating all available assets for the accomplishment of the primary and secondary missions.

To be prepared to understand and train others to facilitate the above missions, the team members receive six weeks of specialized training themselves at an average cost of approximately $1,000 per trainee. The training consists of classes in the areas of Stress Management, Crisis Intervention, Suicide Prevention, Critical Incident Stress Management, Joint CSC Operations, and Combat Stress Control. In addition, trainees receive an introduction to Inpatient Psychiatry Training and Alcohol Treatment Facility Training.

Once trained, members of the OSCAR Team provide valuable services that, according to the MROC Executive Summary “has shown effectiveness with potential for as much as 20% reduction in suicide behavior, mental health related administrative separations and psychiatric hospitalization if implemented throughout the Marine Corps (2003,pg 1). The services provided include Prevention (education and training), Early Interventions, such as suicide risk assessments, and Continuing Actions, such as liaison with other agencies.

The OSCAR program’s predicted success and success thus far has been encouraging and far overshadows the requirement of structural re-assignments of Marine Corps and Navy Personnel and the cost associated with start-up and maintenance of the program ($90k per year). Although the program lacks full implementation into the Marine Air

Ground Task Force (MAGTF), it can provide the following benefits as identified in the 2003 MROC Executive Summary:

- MarDivs already have Div Psych/Psych Tech
- Most potential to reduce psych hosp, admin seps & associated costs
- Less lost work time and fewer med evacuations
- Improved command and Marine satisfaction
- Pilot supported by BUMED and Chaplains
- Improved data collection and analysis
- Supports tailored spiral development Consistent with intent and fulfills DoDD 6490.5
- Expeditionary, can be tasked organized for deployments.

What the OSCAR program does not provide is any form of destigmatization training. A look at some organizations that may provide destigmatization training is discussed in the next subsection.

D. REVIEW OF CIVILIAN DESTIGMATIZATION PROGRAMS

The Mental Health organizations that were reviewed (see Table 6) fought stigma in various ways. What was interesting is that many are listed in published articles, books, and organizations such as the American Psychological Association & American Counseling Association as organizations that fight stigma. However, as can be seen in the table, many actually don’t have a separately titled stigma component, let alone curriculum. The majority promote the idea that through generalized education and awareness, stigma will be reduced.

Table 6 summarizes information about six civilian organizations that address stigma as it relates to mental health. In concert with what several interviewed practitioners alluded to, knowledge is necessary to reduce stigma. Five of the six organizations deal primarily with knowledge/information acquisition and/or dissemination. Means of passing along information include books, brochures, videotapes, discussions, symposiums, teaching packages, internet sites, and public screening days nationwide. Some reasons they exist are to reduce stigma, provide support, produce research, and offer suggestions.

Two of the six organizations use Stigmabusters (a section of the National Stigma Clearinghouse) listed first in the table. This organization believes that the prevalence of misrepresented mental patients and/or actors/actresses with mental illness in shows and movies retard the attempt to destigmatize mental illness. It is to this end that the majority of the other organizations work; to demystify mental illness, to question myths, to promote understanding.

Table 6. Organizations that Fight Stigma

- **NATIONAL STIGMA CLEARINGHOUSE/STIGMABUSTERS**

PURPOSE: Monitors stigma in mass media.
METHOD: Information from STIGMABUSTERS (country-wide program to report media stigma and contacts media professionals to pose concerns and offer suggestions.
SPECIFIC STIGMA COMPONENT: No specific, stigma curriculum component.

- **NATIONAL MENTAL HEALTH ASSOCIATION (NMHA)**

PURPOSE: Improve public knowledge of mental illness/advocate for improved resources.
METHOD: Publication and distribution of materials, nationwide depression screening days.
SPECIFIC STIGMA COMPONENT: No specific, stigma curriculum component. Operates stigma watch, similar to Stigmabuster (see above) and distributes a brochure on stigma, Stigma: Awareness and Understanding of Mental Illness.

- **NATIONAL ALLIANCE FOR THE MENTALLY ILL (NAMI)**

PURPOSE: Mental health advocacy-helps establish support groups.
METHOD: Produces and distributes info about illness and treatment.
SPECIFIC STIGMA COMPONENT: Utilizes affiliate stigmabusters (see above) to combat stigma. No specific, stigma curriculum component. Teaching packages on specific mental illness, such as schizophrenia only.

- **NATIONAL INSTITUTE OF MENTAL HEALTH**

PURPOSE: Communicates information to scientists, public etc. to seek, understand, prevent, and treat mental illness.
METHOD: Provides support for research mainly.
SPECIFIC STIGMA COMPONENT: None, specific programs are geared towards depression and anxiety.

- **THE CENTER FOR MENTAL HEALTH SERVICES (CMHS)**

PURPOSE: To improve treatment and support services for persons with serious mental illness.
METHOD: Operates an internet site, knowledge exchange network (KEN), with info on illness, treatment, and mental health policies.
SPECIFIC STIGMA COMPONENT: Distribution of brochure Before you Label People, Look at Their Contents. No curriculum piece to model available.

- **THE CARTER CENTER MENTAL HEALTH PROGRAM**

PURPOSE: Reducing stigma and improving mental health care.
METHOD: Yearly fellowships for research, panel discussion videotapes, sponsorship of annual symposium to promote mental health discussion.
SPECIFIC STIGMA COMPONENT: No curriculum.

Note. From authors' own compilation of various sources to include resource guides on the Internet that were specifically geared toward addressing mental health stigma. This table is not inclusive of all organizations that address stigma.

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V. CONCLUSIONS AND RECOMMENDATIONS

A. SUMMARY

This exploratory study examined the role that stigma plays in whether or not Marines are taking advantage of available mental health services. A review of the literature from both the civilian and military sectors was presented indicating that stigma is indeed a barrier in utilization of services.

Three practitioners were interviewed to assess the practitioner perspective in regard to stigma. A review of the OSCAR program was then conducted to determine if a destigmatization program may be useful. Lastly, civilian mental health organizations were examined with the purpose of discovering any destigmatization programs which may be used as a model for the Marine Corps' OSCAR program.

B. CONCLUSIONS

Results from practitioner interviews follow:

- That some stigma may exist, but is probably less prevalent than other factors.
- That there is a lack of information/knowledge by individuals (active-duty), family members, and leadership in regard to available mental health services.
- Leadership may be the most important influence on use of mental health services.
    - o Immediate supervisors, as well as CO's, XO's, Sergeants, often refer personnel.

    - Positive or negative opinions of leaders can influence use of services.
    - Leadership generally has a positive view of Marine and referral if problems are solved.

- That counselor preference does not usually pertain to gender or status (i.e., civilian or active duty therapist), but to professionalism nor does it usually pertain to counselor title or credentials either, i.e. use of therapist, counselor, social worker, psychologist, psychiatrist, etc.
- Information is currently available (newcomers programs), but may need to be refreshed.

Results from the OSCAR study reflected the positive direction that the initial pilot study provided the Marine Corps. The program is still in its infancy; however the payoffs should far outweigh the costs. Although the program provided numerous individual and unit level services, destigmatization training was not a piece of the curriculum.

The study of the mental health organizations reflected a preponderance of training which informed the public on mental health illnesses, symptoms, etc., essentially awareness training. Destigmatization programs were only a very small piece of the education and training that they provided. Stigma may be reduced simply by teaching what mental illness is all about, its symptoms, the genetic component; its relation to stress, and ways to cope.

C. RECOMMENDATIONS

Although the initial purpose of this thesis was to ultimately suggest a form of destigmatization training within the OSCAR program, the conclusions lead me to suggest other recommendations.

1. Institute Fleet Orientation/Mental Services Training (FOMST)

Because the practitioner interviews yielded the idea that Marines, both subordinates and leaders, were not as knowledgeable regarding available mental health services as they could be, my suggestion would be for the focus of any training to be, for the most part a pathway to knowledge regarding mental illness, and available mental health services that provide help.

Components of what I will suggest as a Fleet Orientation/Mental Services Training (FOMST) class will be discussed shortly and would serve some of the above mentioned areas. The target audience would be those that are most prone to suicide and non-EAS attrition, our young enlisted, first-term Marines. The timing of the training would most suitably be just prior to Boot Camp graduation, possibly after the Crucible event, but before reaching their first duty station.

What the OSCAR program currently lacks is equality of services to all Division Marines. Understanding that the program is contained only with the Divisions currently, because of its pilot status, it nevertheless, places only Marines under care or who are referred under its umbrella. Except for pre/post deployment briefs, etc. that all Division deploying Marines receive, these other services do not reach all. Nor maybe should it. However, to

incorporate some type of annual training would lead to the possibility of only “some” Marines getting mental services knowledge training. The FOMST training would ensure every single Marine receives training to include reservists.

This training would use very little additional manpower at the Depot (Parris Island and San Diego) level. A senior SNCO or Field/Company grade officer with one or two junior staff/admin workers would undoubtedly be sufficient. If an officer, a Marine with prior enlisted service experience, may be seen in the eyes of the graduating Marines as someone they can more easily identify with.

In fact, the Naval Postgraduate School, Curriculum 856 (Leadership Development & Human Resources Management), taught at the U.S. Naval Academy would be an, in place program, with very beneficial classes for a FOMST trainer. Classes like Adult Development (the concentration is on “young” adults), Counseling, Ethics and Moral Development, Motivation and Empowerment, Managing Diversity, Group Dynamics and Teambuilding, Educational Theory, Military Sociology and Psychology, Conflict Management, as well as many of the other required classes would be an excellent foundation for a trainer.

If an Officer, the Master’s of Science obtained from the above degree could be added as an additional Special Education Program (SEP). A secondary, peripheral benefit of this program would allow officers who currently do not have Military Occupational Specialty (MOS) specific advanced Primary Military Education (PME) training a chance to increase their skills in a diverse and challenging job.

FOMST training would include subject areas that would most benefit a new Marine, areas such as:

- Adjustment Training--Adjustment Disorders are major problems with Marines at SOI, MOS school, and first duty stations. Prior to going on leave, post-Boot Camp Marines need to know that going back to their home towns will be a form of shock. Likewise, the ideal of the Fleet, presented in Boot Camp, is sometimes a shock to Marines who find the fleet to be bereft of the perfect Marine, like their Drill Instructors, in each and every instance.

- Personal Experience/Role Model Discussion--This portion of the program would augment the adjustment training mentioned previously by the use of a guest speaker if the trainer had not gone through boot camp. It would present new Marines with personal experiences from self or others as to change and development that Marines experience after Boot Camp, upon their 30 days leave, at their MOS schools, and upon entering a unit. This form of indirect experience exposure may alleviate a sense of the unknown which may reduce the stress of transition and, ultimately, reduce a few administrative discharges.

- Stress training--This would also, like the OSCAR program, be consistent with the intent and fulfill Department of Defense Directive 6490.5, which was mandated post-USS Cole incident. Again, the benefit here, is that ALL Marines, whether active duty or reservist, whether working in the Division, Wing, or at an Inspector-Instructor (I&I) staff in a remote location would be FOMST trained.

- Advice in seeking mentors.

- Mental Illness; types, symptoms and sources of help.

- Character Development--Minimal amounts of character and moral development have been added to the Marine Corps Martial Arts Training program. However, the degree and consistency of the character piece may differ by unit and trainer. The U.S. Naval Academy spends enormous amounts of energy, manpower, and monies in support of Character Development training for future Navy and Marine Corps officers. Should it not be assumed that enlisted Marines, many of whom come from considerably more disadvantaged circumstances as these future officers, could benefit from discussions on ethics, morality, and character building?

- Self-awareness and personality tests-—Aristotle's maxim "Know Thyself" is as relevant to enlisted members as it is to officers. Again, using the U.S. Naval Academy as an example, all Midshipmen are given various tests to help them understand their strengths and weakness, as well as general dispositions, etc. One example is the Meyer's Briggs Type Indicator (MBTI). This training may be more appropriate at the Corporal's course, however, as test taking and interpretation are both time-consuming.

Brochures that some of the organizations listed in the previous chapter could be handed out during the training as well.

Lastly, the efficacy of this training would not require additional tracking tools or research teams. Although this training suggests many individual

developmental benefits, the main goal is to reduce attrition. The same systems for tracking non-EAS attrition, suicides, etc. could be used to investigate any changes in these rates after FOMST is incorporated. Other than the above stated recommendation for FOMST training, the subsequent sections involve other recommendations of a diverse nature.

2. Separate Service Facility

With the greater numbers of service members being married, the base counseling centers that not only provide pre-deployment briefs, also provide services to family members. Spouses and children certainly are affected by some of the same stressors of military life that affect service members. However, recent changes in confidentiality and patient privileges sometimes necessitate Fleet and Family Support Centers to turn away active duty members because a conflict of interest arises if a spouse happened to be seen first. When the stress of an impending divorce causes a service member to seek stress relief by way of counseling it is truly a travesty when he or she is told to try the next base over.

A way to alleviate this problem is to provide separate facilities for the service member to go to. Not only might they feel more comfortable in the waiting room, among other uniformed personnel and away from spouses of friends, co-workers, and their own family members, but they wouldn’t feel the sting of feeling like a second rate citizen over the non-uniformed seekers. A separate facility may also be more expedient if close to the unit. The United States Naval Academy not only has separate facilities for its midshipmen, but allows visits on a walk-in basis. One

reason is that the midshipmen's time is seen as vitally important. Is it not for the fleet Marine or Sailor as well?

I would go so far as to argue that it would be "fair," in fact, to allow service members to seek treatment outside of the military care system as is the possibility for sponsored civilians. TRICARE currently allows family members eight counseling visits at a civilian non-TRICARE facility with little questions asked. Yet the military members must risk the stigma and other consequences of the current system without the possibility of an alternative method of seeking help, unless, of course, they pay on their own.

3. Educate about Causes and Effects of Stress

We have a tendency in society to be reactive rather than proactive. The military is sometimes no different and our health care system, to include our mental health care system, reflects it. Again, this is an area in which some improvements have been made. The OSCAR program is an example of this. At least we recognize mental health as a component to performance and the overall health of a service member. The Navy has incorporated medical assessment surveys by Occupational Health in order to proactively combat and educate members on various habits which may cause them future physical and psychic harm down the road. The Marine Corps adopted Semper Fit many years back which also promotes health in more profound ways than simply advocating running and humping 30 miles a week.

However, we can do more. We can extensively educate our troops, and officers, as to the negative physiological effects of stress. This information can be vitally useful

in advocating stress relief methods such as breathing, yoga, meditation, cognitive restructuring etc., as ways to combat stress. We routinely educate about the ills of nicotine use by statistics and graphics. Incorporating some method of graphically displaying the body's reaction to stress could be equally effective. Just as grade school children learn how the body system works by watching food enter the body and working its way through the body system, via computer generated pictographs, troops could learn from watching a body system losing beneficial brain chemicals such as serotonin when the Staff Sergeant screams non-stop or watching the blood pressure rise in the circulatory system when the Colonel loses his/her composure. This is not suggested as new training, but refinements of the plethora of stress training resident to the Marine Corps already.

4. Improve Specific Screening

Although stress reactions are known to develop during fleet time where no neurosis existed previously, *some* combat stress casualties, and, in fact, some who are simply a product of non-EAS attrition where no combat is involved, are due to pre-existing conditions. These conditions can be screened out to a greater extent if our recruitment efforts include greater and more varied questions regarding mental health and past reactions to stressful events. The extra time and expense dedicated towards this cause would, at a minimum, create the beginnings of documentation that is a necessary part of many discharges that seem to be interminable due to a lack of substantiating documentation.

5. Appropriate Leader Behavior and Attitudes

The requirements of leaders are great. With increased expectations and improved (less inflated) fitness reporting

it is more difficult to squeak by on a modicum of higher order management skills. Leadership is at a premium and provides, among other things, the necessary guidance that subordinates need/want. A leader can guide a subordinate in how to deal with stressful situations, how to maintain a sense of calmness under pressure. This is done through modeling.

This concept may seem obvious. It is certainly discussed enough under the guise of "leadership by example." But, there are still plenty of great senior leaders, one's who care and are competent, but that will not relinquish old school ways of screaming and yelling when things go wrong. They think troops need to feel the wrath; that it makes for a "hard" Marine. What they fail to realize is that they are displaying poor emotional control that can be learned by the subordinate who, in later years, becomes a "screamer" him or herself. Never do they consider that the yelling can reflect a weakness, a weakness that does not necessarily make harder, tougher troops. We need leaders that model appropriate behavior in stressful situations. Leaders should be taught how to "fire for effect" in the office as well as on the range. Paying lip service to important new information regarding stress by means of messages and dictates do little if emphasis is not placed on the same from higher.

Other than proper modeling, leaders should reflect positive attitudes toward mental health services. To accomplish this it would be useful for leaders to maintain a current working knowledge of available services and encourage participation (without reprisal) for all those who are command-referred or self-referred to clinics.

Lastly, leaders who have personally benefited from mental health services should be encouraged to tell their stories and be advocates of the system that they personally benefited from. This technique, often by famous celebrities, has been extremely useful in the civilian sector destigmatization programs (Johnson, 1994).

6. Incorporate Books in Commandant's Reading List

There are myriad books available that could be added to the Commandant's Reading List. These same books could be incorporated in school-houses such as at The Basic School (TBS), the Gunnery Sergeant's course, etc. One example that would be appropriate due to current events is An Operators Manual for Combat PTSD: Essays for Coping by Ashley Hart II.

7. Dissemination of Information

Although education has already been promoted several times, in the form of FOMST training for entry level Marines) and leadership awareness/training (for leaders such as Non-Commissioned Officers and Commanding Officers and Executive Officers), it is important to emphasize that all Marines, to include ranks/billets not mentioned, be knowledgeable. Likewise, family members should be equally knowledgeable about mental illness, emotional distress symptoms, and available services. For both active duty members and family members, local websites, such as those of base Fleet and Family Service Centers should provide more of an educative piece to their site rather than just the service offerings. Additionally, brochures should be prevalently displayed in appropriate and visible command periodic displays as well as hospitals, commissary, etc., where family members are more apt to see them.

8. Promote/Maintain Proactive Rather than Reactive Mentality

The last recommendation suggests that commands and leadership promote early detection of potential personnel problems. As the OSCAR program emphasizes, prevention is a better end state than a cure. In McCaroll's (1993) study of Army Community Mental Health an interesting finding was discovered. A synopsis follows:

> It was surprising to us that two diagnoses that do not represent psychiatric disorders, phase of life or other life circumstances problem and occupational problem, accounted for more than 50% of the diagnoses reported on a population of almost 3,000 clients in a 20-month period.

Having life difficulties, without mental disorders, should bar no one from taking advantage of counseling services. The military would do well to allow, and more importantly, promote, Marines to receive treatment for temporary stressors in order to possibly prevent more problematic issues such as attrition and suicide.

D. CAUTION

None of the recommendations, at a quick glance, would appear to be cost prohibitive, except possibly civilian sector counseling services for active duty Marines. However, the payoff in reducing suicide and non-EAS attrition, as well as dealing w/ PTSD, could be significant. At a minimum, they are suggested as unique recommendations as not to counter General Krulak's mandate from many years ago:

"Program and service integration of closely related activities in order to maximize synergy, eliminate unnecessary bureaucracy, and reduce the possibility of duplicative or Counterproductive efforts." (almar 355/98)

For example, the FFSC gives classes on Stress Management. The OSCAR program is intended to assist in Stress Control by, among other things, classes on stress. Yet (CREDO), gives a brief that addresses combat stress: its symptoms, its effects, etc. This Warrior Transition brief, as it was coined, is the stress class of choice and has been given to over 10,000 Marines returning from combat as mandated by the Commandant of the Marine Corps (U.S. Naval Academy Chaplain staff and CREDO, Norfolk email, 2004). Although the previously mentioned stress classes are undoubtedly different in various ways, there might possibly be some redundancy and begs the question regarding duplicative services.

E. SUGGESTIONS FOR FURTHER RESEARCH

The limitations to this study included the very small sample size of practitioner interviews to assess practitioner perspectives regarding stigma. Although a main purpose of this was to provide illustrative and anecdotal information to augment the abundance of available stigma literature, nevertheless, it is too small a sample size to generalize. A different population, that of Marines instead of practitioners, may be worthy of study. It would be interesting and beneficial to research the degree of stigma that Marines feel toward mental health services. More importantly, it may be enlightening to question their knowledge of available resources in addition to perceived stigma.

Additionally, the organizations that were looked at for this study were at the national level. A representative of National Alliance for Mentally Ill (NAMI) informed me that a study of programs conducted at the local level would be worthwhile. Still stigma would, in most cases, only be a small component of an otherwise non-stigma class, i.e. awareness class. This further implicates "knowledge" of Marine Corps Mental Health services as being just as worthy of promoting as specific destigmatization training in any classes we may create.

F. CLOSING

The question that continues to concern me is whether the services are underutilized, due to stigma and lack of services awareness. Aside from my personal experiences, the literature review and practitioner interviews suggest that stigma and lack of knowledge regarding available services contain room for improvement. In fact, even the most recent studies coming out of IRAQ confirm these areas to be barriers to treatment. As a Marine once told me, "Hope is not a good course of action." Hopefully, this thesis will generate new studies and, ultimately, refinements in a very good military mental health-care system that could be even better.

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APPENDIX: INTERVIEW PROTOCOL

1. How many years have you counseled within the military sector?

2. Do you have any experience counseling within the civilian community?

3. From your dealings with unit CO's, XO,'s, Sergeant Majors, and Legal Officers, do you find that negative stigma is attached to those that seek counseling? If so, can you give any examples?

4. If stigma exists, is it the same for officers and enlisted? Does one group or the other worry more about the ramifications of seeking treatment?

5. Are there barriers that prevent Marines from seeking treatment? What are they?

6. Do Marines articulate a preference in whom they prefer to conduct counseling with, i.e. uniformed or not? (FFSC, Outpatient Psychology Clinic, Chaplain, Unit level Marine?)

7. Do you see a need for destigmatization training in the Marine Corps? Under what umbrella (i.e. FFSC, Outpatient Psychology Clinic, Chaplain, OSCAR program, Unit level)?

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